Rep. Tabersak HB 5387

State of Maryland

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Carrier or Appropriate Recipient:
Magellan Behavioral Health
Fax: 800-365-5030
- or -
PO Box 4930
Columbia, Maryland 21046-4930

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH ___/___/____

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER NAME, ADDRESS & PHONE

Date Patient First Seen For This Episode Of Treatment ___/___/____

Have you communicated with the PCP/other relevant health care practitioners about treatment? O Yes O No

DSM-IV MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)

AXIS I Dx Code ___.___ Dx Code ___.___

AXIS II Dx Code ___.___

AXIS III Does the patient have a current general medical condition that is potentially relevant to the understanding or management of the condition(s) noted in Axis I or II? O No O Yes

AXIS IV Severity of current psychosocial stressors
O None O Mild O Moderate O Severe

AXIS V: GAF Score Highest Past Year ___ At first Session ___ Current ___

Current Medications (if not applicable, no response is required)

O Anti-psychotic O Anti-anxiety O Anti-depressant O Psycho-stimulant O Injectables
O Hypnotic O Non-psychotropic O Mood stabilizer/Anti-convulsant O Other

Symptoms

Please rate the patient's current status on these symptoms, if applicable. If not applicable, no response is required.

	Ideation	Plan	Prior Attempt	None		Present	Absent
Suicidal ideation	O	O	O	O	Self-injurious behavior	O	O
Homicidal ideation	O	O	O	O	Substance use problems	O	O

Authorization Request Details

CPT Code _____ Number of Units ___

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: ___/___/___

Complete this section only if a second CPT is needed.

CPT Code _____ Number of Units ___

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: ___/___/___

Signature of practitioner: _____ ___/___/____ Date

My signature attests that I have a current valid license in the state to provide the requested services.

MHN
A Health Net Company

October 15, 2010

RE: IMPORTANT CHANGES REGARDING MHN'S OUTPATIENT MANAGEMENT PROCESS

Dear Practitioner,

As part of MHN's continuing efforts to improve the quality and effectiveness of our services, and to meet the expectations of the new Federal Parity law, MHN is modifying its Outpatient Management process. Effective 10/15/10, MHN is introducing two major changes to the management process of outpatient office based treatment covered under Managed Care benefits.

1. Elimination of Reauthorization Process
2. Introduction of New Registration Process

Elimination of Reauthorization Process:

Practitioners will no longer need to obtain reauthorization in order to continue treatment by submitting a Request for Reauthorization (RFR) form or Outpatient Treatment Request (OTR) forms. Practitioners are expected to continue to treat MHN members as efficiently and effectively as possible to meet their clinical needs

MHN will continue to manage outpatient care received by its members by engaging in a quality management process to monitor each practitioner's overall practice. Practitioners on occasion may be contacted by a Clinical Care Manager from MHN to discuss individual cases where there appears to be a marked variance from the standards of care. It is MHN's goal in this process to ensure our members receive clinically appropriate treatment consistent with the applicable terms of coverage.

Eligibility status is subject to change due to a variety of possible circumstances (i.e., termination of employment, elective change of benefit plan) Practitioners should monitor member eligibility and ensure that members have advise them of any changes. Practitioner questions about eligibility may be directed to the Member Service team listed on the back of the patient's ID card.

Introduction of New Registration Process:

Registration is different than prior authorization because access to care is facilitated through the registration process. This is a notification to MHN of treatment, not a request to treat a member. Practitioners will no longer receive authorization letters

Members and/or practitioners are strongly encouraged to register their treatment of new members by contacting the Member Service team at the toll free number indicated on the back of the member's identification card. For plans that are not subject to federal parity law, the registration process is required and penalties may be applied if there is a failure to register care with MHN.

Registration of treatment by contacting MHN will accomplish the following:

District of Columbia

Release of Mental Health Information for Outpatient Mental Health Treatment

This form is designed to authorize the disclosure of the mental health information listed below by the individual practitioner to determine entitlement and payment of claims for reimbursement. It is not to be used for in-patient or partial hospitalization.

Carrier or Appropriate Recipient:
Magellan Behavioral Health
Fax: 800-365-5030
- or -
PO Box 4930
Columbia, Maryland 21046-4930

CLIENT INFORMATION

CLIENT'S FIRST NAME

CLIENT'S DATE OF BIRTH ☐☐/☐☐/☐☐☐☐

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER NAME, LICENSE#, ADDRESS & PHONE (Fax optional)

Date Client First Seen For This Episode Of Treatment ☐☐/☐☐/☐☐☐☐

Status? O Voluntary O Involuntary

MULTIAXIAL DIAGNOSIS CODE (PLEASE COMPLETE ALL FIVE AXES)*

*DSM, ICD or Other Recognized Code

AXIS I Dx Code ☐☐☐.☐☐ Dx Code ☐☐☐.☐☐

AXIS II Dx Code ☐☐☐.☐☐

AXIS III (if relevant)

AXIS IV Severity of current psychosocial stressors
O None O Mild O Moderate O Severe

AXIS V: GAF Score Highest Past Year ☐☐ Current ☐☐

Current Medications and prescribing practitioner (if applicable):

Reason for Continuing Treatment and Treatment Goals:

Prognosis (limited to estimated duration of treatment):

Authorization Request Details

Modality of treatment maybe conveyed via CPT code or by describing in the field provided below.

(Modality examples: individual psychotherapy, group psychotherapy, medication management)

CPT Code ☐☐☐☐☐ or Modality:

Frequency (once a week, etc.):

Requested Start Date of Authorization: ____/____/____

Complete this section only if a second CPT/Modality is needed.

CPT Code ☐☐☐☐☐ or Modality:

Frequency (once a week, etc.):

Requested Start Date of Authorization: ____/____/____

Client's Consent: By signing below, I agree to share this information with the designated 3rd party payer (administrator). I also understand that, "The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the Client or as provided in Titles III and IV of that Act. The Act provides for civil damages and criminal penalties for violations."

Signature of Client
- or -
Date:

Signature of practitioner*
Date:

*My signature attests that I have consent from the Client to release this information.

Initial Wellness Assessment (Adult)

Everybody who uses services through United Behavioral Health (UBH) or U.S. Behavioral Health Plan, California (USBHPC) is asked to complete this brief questionnaire. It will help us measure whether the services were helpful in meeting your needs. Please answer each item as best you can, based on how you are feeling today. We encourage you to discuss your answers with your clinician. That way, together you can achieve the best possible results.

We may review your answers to see if we can offer you additional resources or support. We may also review your answers with your clinician if we believe that will help you.

We respect your privacy and confidentiality. Your answers will not be revealed to your employer or health plan.

Your response is very important to us. It is one of the best ways we can understand your concerns and help you get the assistance you need. While we urge you to complete this questionnaire, you are not required to do so. This questionnaire will not affect your eligibility for services through UBH or USBHPC.

If you have any questions about this questionnaire, please call the number on the back of your enrollee identification card.

Your Information (Please print. All fields are required.)

First Name: _____ Last Name: _____

Date of Birth: __/__/____ Gender: ☐ Male ☐ Female Subscriber ID: _____

1. Please indicate the PRIMARY problem that has led you to seek help today.

- ○ Depressed mood
- ○ Anxiety or worry
- ○ Grief or loss
- ○ Relationship/family problems
- ○ Occupational problems
- ○ Substance use problems
- ○ General stress
- ○ Physical health problems
- ○ Other emotional/psychological problems

	Not at all	A little bit	Somewhat	Quite a bit	Extremely
2. How much have the problems which have led you to seek help bothered you in the past 30 days?	○	○	○	○	○
3. In the past 30 days, to what extent have the problems which led you to seek help interfered with your:					
a. Family life	○	○	○	○	○
b. Social life	○	○	○	○	○
c. Work, schoolwork, or housework	○	○	○	○	○
d. Health and physical well-being	○	○	○	○	○

4. Following are problems or complaints that people sometimes have. For each problem please indicate how much that problem has bothered or distressed you during the past seven days, including today.

	Not bothered	A little bothered	Moderately bothered	Quite bothered	Extremely bothered
a. Nervousness or shakiness	○	○	○	○	○
b. Feeling lonely	○	○	○	○	○
c. Feeling sad or blue	○	○	○	○	○
d. Your heart pounding or racing	○	○	○	○	○
e. Feeling hopeless about the future	○	○	○	○	○
f. Feeling everything is an effort	○	○	○	○	○
g. Spells of terror or panic	○	○	○	○	○
h. Feeling so restless you couldn't sit still	○	○	○	○	○
i. Feelings of worthlessness	○	○	○	○	○
j. Feeling suddenly scared for no reason	○	○	○	○	○
k. Feeling no interest in things	○	○	○	○	○

Please continue on the next page (1 of 3)

Your Name (please print): _____

	Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
5. Please tell us how much you agree with the following three statements:					
a. I feel good about myself.	O	O	O	O	O
b. I can deal with my problems.	O	O	O	O	O
c. I am able to maintain control over my life.	O	O	O	O	O

	Yes	No
6. Are you currently employed? (If yes, please proceed to question 7 below. If no, please skip to question 11 below.)	O	O
7. During the past 30 days, how many days were you unable to work because of your physical or mental health?	☐ Days	
8. During the past 30 days, how many days did you work, but had to cut back on how much you got done due to your physical or mental health?	☐ Days	

	Yes	No
9. Are you receiving, have you filed, or are you considering filing for disability benefits or workers' compensation? (Your answers will be kept completely confidential)	O	O
10. Are you having any recent problems at work?	O	O
11. Are you caring for someone in your family who is ill or disabled?	O	O

	Excellent	Very Good	Good	Fair	Poor
12. In general, would you say your health is:	O	O	O	O	O

	Not bothered	A little bothered	Moderately bothered	Quite bothered	Extremely bothered
13. In the past 30 days, how much have you been bothered by physical pain?	O	O	O	O	O

	Yes	No
14. Do you now have a serious and/or chronic medical condition such as diabetes, cancer, heart disease, asthma, or rheumatoid arthritis?	O	O

If yes, please indicate the medical condition(s) _____

	Zero	1	2-3	4-5	More than 5
15. In the past six months, how many times have you seen a medical doctor or used other medical services?	O	O	O	O	O

	Yes	No
16. Have you had a drink or used drugs in the past 30 days? (If yes, please proceed to question 17. If no, please skip to question 23.)	O	O
17. In the past 30 days, have you ever felt you ought to cut down on your drinking or drug use?	O	O
18. In the past 30 days, have people annoyed you by criticizing your drinking or drug use?	O	O
19. In the past 30 days, have you ever felt bad or guilty about your drinking or drug use?	O	O
20. In the past 30 days, have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	O	O
21. How many days in the past week did you have a beer, glass of wine, mixed drink, or shot of liquor?	☐ Days	
22. On a typical day when you have had a drink, how many glasses, bottles, cans, and/or shots do you drink?	☐ (Enter # of glasses, bottles, cans, and/or shots)	

Please continue on the next page (2 of 3)

Your Name (please print): _____

23. Please tell us how much you agree with the following statements regarding UBH/USBHPC:

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a. The information and resources I received were useful.	O	O	O	O	O
b. My calls were answered in a reasonable time.	O	O	O	O	O
c. I received information I requested in a reasonable time.	O	O	O	O	O
d. The staff were helpful.	O	O	O	O	O
e. If the need arose I would use these services again.	O	O	O	O	O

24. Please tell us how much you agree with the following statements regarding finding a clinician:

a. I was satisfied with my experience of finding an available clinician.	O	O	O	O	O
b. My first appointment with a clinician took place within an acceptable timeframe.	O	O	O	O	O

25. We would like to see how well we serve different ethnic groups. Please tell us the ethnic group that you identify with most:

- O White, non-hispanic
- O African American or Black
- O Latino or Hispanic
- O American Indian or Alaska native
- O Asian or Pacific Islander
- O Multiple ethnic groups
- O Other ethnic groups
- O Do not wish to disclose

26. In order for us to measure the helpfulness of our services to you, may we mail you a brief Follow-up Wellness Assessment in a few months?

Yes	No
O	O

Thank you for taking the time to complete our Wellness Assessment.
Please review your answers with your clinician.

For Clinician Use (Please print. All fields are required.)

Clinician Name

First Name: _____ Last Name: _____

Phone Number: (___) ___ - ____ Authorization Number: _____

Date assessment given to client: __ / __ / ____

If your client did not agree to complete the assessment, please initial here _____.

NOTE: You must submit this form to UBH/USBHPC to notify us of treatment, whether your client chose to complete it or not. Please be sure the client information on page 1 is complete before you do so.

Reviewing your client's responses helps enhance treatment planning and assess outcomes.

Please indicate that you have reviewed the responses with your client by initialing here _____.

Please return this form to UBH/USBHPC:

Toll-free fax: 1-800-864-8120

Mail: UBH/USBHPC, ATTN: BHS-Wellness Assessment
PO Box 601520
San Diego, California 92160-1520

Note: Blank copies of this form may be photocopied for use with other clients.

ALERT®

Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name , First Name Child's Date of Birth: (mm/dd/yy) / /

Subscriber ID Authorization #

Clinician Last Name , First Name Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID Clinician Phone - State MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

Clinician: Please fax to (800) 985-6894

CONNECTICUT
Behavioral Health Partnership

PSYCHOLOGICAL TESTING REGISTRATION FORM

PLEASE COMPLETE AND FAX TO: 1-(866)-434-7681

Provider EDS/CMAP ID # (Medicaid 8-digit ID) _____

Name of clinician who filled out this form _____ Credentials/Title _____

Contact number _____ Ext._____

Facility/Provider Name_____ Telephone Number_____

Facility/Provider Service Location _____

Member Name _____

Medicaid/Consumer ID# _____ DOB: _____ *ANDIOR* SSN: _____

QUESTIONS:

1. RACE (optional): ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific ☐ White
2. ETHNICITY: Hispanic/Latino Origin (optional): ☐ YES ☐ NO
3. REFERRAL SOURCE: ☐ Self/Family Member ☐ PCP/Medical Provider ☐ Step Down Intermediate LOC ☐ Step Down Inpatient LOC ☐ Other BH Provider ☐ School ☐ Comm. Collaborative ☐ CT BHP ASO ☐ DCF ☐ DMR ☐ DMHAS ☐ Hospital Emergency Dept ☐ Managed Service System ☐ Court-ordered ☐ Other Legal ☐ Other
4. FIRST DIRECT SCREENING W/ MEMBER: Date_____
5. SCREENING TYPE: ☐ Walk-In ☐ Telephone
6. REFERRAL TYPE: ☐ Routine ☐ Urgent ☐ Emergent
   a. If Routine or Urgent: Date Appt. Offered: _____ Did Member Accept the Appointment? ☐ YES ☐ NO
      Date of first face-to-face Clinical Evaluation: _____
   b. If Emergent: Date and Time Presented at the Clinic: _____ DATE _____ AM / PM
      Date and Time of Clinical Evaluation: _____ DATE _____ AM / PM
7. AXIS I – V (AXIS IDSM IV Diagnosis Code)
   a. AXIS I & II
      AXIS I _____ (circle one: Primary, Secondary, Rule Out)
      AXIS I _____ (circle one: Primary, Secondary, Rule Out)
      AXIS II (If deferred, pls indicate)_____ (circle one: Primary, Secondary, Rule Out)
      AXIS II _____ (circle one: Primary, Secondary, Rule Out)
   b. AXIS III: ☐ None ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cardiac Problem ☐ Chronic Pain ☐ Cystic Fibrosis ☐ Eating Disorder ☐ HIV ☐ Hearing Impairment ☐ Hepatitis ☐ Lupus ☐ Mobility Impairment ☐ Neurological disorder ☐ Obesity ☐ Pregnancy ☐ Post-partum ☐ Sickle Cell ☐ Traumatic Brain Injury ☐ Type I Diabetes ☐ Type II Diabetes ☐ Visual Impairment ☐ Other Axis III _____
   c. AXIS IV: _____
   d. AXIS V (GAF Score ✓ & enter appropriate #) ☐ 1-10_____ ☐ 11-20 _____ ☐ 21-30 _____ ☐ 31-40 _____
   e. ☐ 41-50 _____ ☐ 51-60 _____ ☐ 61-70 _____ ☐ 71-80 _____ ☐ 81-90 _____ ☐ 91-100 _____
8. If member had previous behavioral hlth treatment within the past 6 mos. Select all that apply: ☐ N/A ☐ Mntl Hlth ☐ Sub Abuse
9. Are there family members or significant others involved in the members treatment and recovery? ☐ YES ☐ NO ☐ N/A
   a. If yes, are any of the family members/significant others receiving their own MH or SA treatment? ☐ YES ☐ NO

10. Have you obtained consent to contact:
    a. School ☐ YES ☐ NO ☐ DENIED
    b. Medical Provider ☐ YES ☐ NO ☐ DENIED
    c. Previous behavioral health treatment provider ☐ YES ☐ NO ☐ DENIED ☐ N/A
    d. BH treatment provider for family member/significant other ☐ YES ☐ NO ☐ DENIED ☐ N/A

11. Who is the lead case management provider? ☐ None ☐ DCF Case Worker ☐ DCF Enhance CC ☐ CC (System of Care Collaborative) ☐ DMHAS Case Manager

12. Is the member currently taking psychiatric medications? ☐ YES ☐ NO

13. Is a psychiatric medication evaluation or medication management visit indicated? ☐ YES ☐ NO

14. Does member have co-occurring mental health and substance use conditions? ☐ YES ☐ NO ☐ Not Assessed

15. If the member is involved with the legal system, please select all that apply

    a. ☐ Juvenile Justice ☐ N/A ☐ Probation ☐ Parole ☐ Other Court

16. Have you provided information regarding peer support or self-help options? ☐ YES ☐ NO

17. Effective date/Start date of authorization? (EX: 09/01/06): _____

FEDERAL REPORTING REQUIREMENTS *ONLY* FOR MEMBERS 0-17 YEARS OF AGE

18. SED (Seriously/Severely Emotionally Disturbed): ☐ YES ☐ NO ☐ UNKNOWN

19. Co-Occuring Disorder: ☐ YES ☐ NO ☐ UNKNOWN

20. Living Situation ☐ Independent Living w/Supports ☐ Crisis Stabilization Residential ☐ Foster Care (Therapeutic or Professional) ☐ Foster Care (Standard) ☐ Group Home ☐ Homeless ☐ Jail/Correctional Facility ☐ Private Residence ☐ Psychiatric Residential Treatment Facility ☐ Residential Treatment Center ☐ Safe Home ☐ Shelter

21. Within the past 12 mos. has the child/youth been: Arrested? ☐ YES ☐ NO ☐ UNKNOWN
    a. Suspended/Expelled? ☐ YES ☐ NO ☐ UNKNOWN

ADDITIONAL REQUIRED QUESTIONS *ONLY* FOR PSYCH TESTING

1. Who initiated the referral? _____

2. What is the referral question? _____

3. What is the patient's history including summary of psychosocial/medical info; treatment history; and type, duration, and frequency of current services? _____

_____

_____

_____

4. What were the results of previous testing including dates and findings? _____

_____

5. What is the differential diagnostic question that the testing will answer? _____

_____

6. What are the treatment options that are being considered? _____

_____

7. What treatment decision requires input from testing? _____

_____

8. List test(s) planned and time required for each test. (i.e. Rorschach 2 hours, Thematic Apperception Test 1 hour, etc.)

Specific Tests Planned	Hours required

CONNECTICUT

CT BHP Concurrent Review/Re-Registration Manual Form

Please complete this form and fax to 1-860 263 2065, Attn: Clinical-OTP Concurrent Review.
If you have any questions, please call 1 877-552-8247

LEVEL OF CARE: ☐ Outpatient ☐ FST ☐ Methadone Maintenance

Name of person completing Form:	Title/Credential:	Phone#:
Facility/Practitioner Name:		Facility/Provider Medicaid ID:
Member name and ID #:		
Prior Authorization #: U_____		The Date the 28th Unit was Used:
Indicate Degree of Progress from previous registration:	☐ None ☐ Minimal ☐ Moderate ☐ High	
Indicate current level of stability:	☐ Not Stable ☐ Somewhat Stable ☐ Stable	
Indicate proximity to baseline	☐ Not Close to Baseline ☐ Close to Baseline	

Currently receiving psychotropic meds? ☐ Yes ☐ No *If Yes, select all class(es) of meds that apply:*
☐ Antidepressant ☐ Antipsychotic ☐ Mood Stabilizer ☐ Antianxiety ☐ Stimulant ☐ Prescribed Pain Reliever

Has a documented decision taken place with member (or his/her guardian) about the effectiveness of treatment and progress being made? ☐ Yes ☐ No

Does a documented goal oriented treatment plan exist? ☐ Yes ☐ No

Members current symptoms: *(Select all that apply)*
☐ Suicidal Ideation ☐ Suicide Attempt ☐ Disassociative ☐ Homicidal Ideation ☐ Physically Assaultive
☐ Verbally Aggressive ☐ Psychotic Symptoms ☐ Substance Abuse/Depend ☐ Self injurious behaviors ☐ Firesetting
☐ Intrusive Flashbacks ☐ Depression ☐ Elevated Mood ☐ PTSD/Trauma ☐ Beh.Problems/School/Home ☐ Anxiety

Risk factors: *(Select all that apply)*
☐ Access to weapons ☐ History (Hx) of violence ☐ Hx of homicidal ideation ☐ Family violence ☐ Hx of explosive/impulsive behaviors ☐ Hx of self injury ☐ Hx of suicidal ideation ☐ Hx of serious suicide attempts ☐ Hx of Sexual abuse
☐ Hx of unsuccessful treatment ☐ Financial ☐ Medical condition ☐ Psychosis ☐ High Sub Abuse Relapse Risk
☐ Recent significant loss ☐ Sole caretaker of family member ☐ Unstable housing ☐ Legal issues ☐ DCF Involvement
☐ Psychiatric/SA issue with Parent/caretaker ☐ Separation from parent ☐ Hx of severe neglect/abuse ☐ Hx. of trauma
☐ Family Dysfunction ☐ Other

Enter AXIS I Diagnosis Date	AXIS I Diagnosis Code(s)	AXIS II Diagnosis Code(s)
AXIS III		
AXIS IV		AXIS V *(Indicate GAF Score1-100)*

Treatment modalities to be used for this request? ☐ Individual ☐ Family ☐ Group ☐ Med Management

Achievement of current treatment goals by: *(Enter Date)*

If Member is 18 or below, please complete the following:

During 90 days prior to this request for re-authorization has:
Member been enrolled in school? ☐ Yes ☐ No, Graduated ☐ No, Expelled ☐ No, Dropped Out
If yes: Member been suspended from school?: ☐ Yes ☐ No
Member had unexcused attendance problems?: ☐ Yes ☐ No
Member's behavior resulted in new legal problems?: ☐ Yes ☐ No ☐ Don't Know
Any new legal charges brought against member?: ☐ Yes ☐ No ☐ Don't Know
Family member been involved in any peer support activities? ☐ Yes ☐ No ☐ Not Applicable
Member been actively involved in any organized recreational activities?: ☐ Yes ☐ No ☐ Don't Know
Does the child's care plan include a goal of involvement in organized recreational activities?: ☐ Yes ☐ No ☐ Don't Know

During past 3 months, have you communicated w/ PCP or other medical provider?: ☐ Yes ☐ No

During past 3 months, have you communicated w/any of the following regarding care and treatment of Member?:
School ☐ Yes ☐ No ☐ Child not enrolled in school
DCF ☐ Yes ☐ No ☐ Child not DCF involved
Probation/Parole ☐ Yes ☐ No ☐ Not involved w. Probation/Parole

METHADONE MAINTENANCE

How long has the member received methadone services? ☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs
Services included in treatment plan? ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP ☐ Other BH Services ☐ PCP/MD Follow-up
What is the ultimate treatment goal? ☐ Methadone Maintenance ☐ Abstinence

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CONNECTICUT
Behavioral Health Partnership

REGISTRATION FORM for Outpatient, Family Support Team (FST), Methadone Maintenance & Ambulatory Detox

PLEASE COMPLETE AND FAX TO: 1-(866)-434-7681

Provider EDS/CMAP ID # (Medicaid 9-digit ID) _____
Name of clinician who filled out this form _____
Contact number _____ Ext:_____ Credentials/Title _____

Facility/Provider Name_____
Facility/Provider Service Location _____ Telephone Number_____

Member Name _____
Medicaid/Consumer ID# _____ DOB: _____ *AND/OR* SSN: _____

REQUESTED LEVEL OF CARE: ☐ Outpatient ☐ FST ☐ Methadone Maintenance ☐ Ambulatory Detox

QUESTIONS:

1. **Registering for a 90801 Initial Evaluation Only?** ☐ YES ☐ NO ***Note: Selecting yes will authorize (1) unit only. If yes, proceed to #18***
2. **Is this a new admission to outpatient services within your agency/practice?** ☐ YES ☐ NO
3. **Is member being discharged from a higher level of care within your agency/practice?** ☐ YES ☐ NO ***Note: (If n/a, select no)***
4. **RACE (optional):** ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific ☐ White
5. **ETHNICITY: Hispanic/Latino Origin (optional):** ☐ YES ☐ NO
6. **REFERRAL SOURCE:** ☐ Self/Family Member ☐ PCP/Medical Provider ☐ Step Down Intermediate LOC ☐ Step Down Inpatient LOC ☐ Other BH Provider ☐ School ☐ Comm. Collaborative ☐ CT BHP ASO ☐ DCF ☐ DMR ☐ DMHAS ☐ Hospital Emergency Dept ☐ Managed Service System ☐ Court-ordered ☐ Other Legal ☐ Other
7. **FIRST PHONE OR WALK IN CONTACT W/ MEMBER OR PARENT/GUARDIAN:** Date_____
8. **FIRST CONTACT WAS:** ☐ Walk-in ☐ Telephone
9. **REFERRAL TYPE:** ☐ Routine ☐ Urgent ☐ Emergent
   a. **If Routine or Urgent:** What was the 1st appt. that was offered to the member: _____
      What was the date of the 1st appt. that was accepted by the member? _____
      If applicable, # of no-shows/cancellations prior to first appt? (Indicate #) _____
      Date of first face-to-face Clinical Evaluation: _____
   b. **If Emergent :** Date and Time Presented at the Clinic: ____/____/____ DATE _____ AM / PM
      Date and Time of Clinical Evaluation: ____/____/____ DATE _____ AM / PM
10. **AXIS I – V (AXIS IDSM IV Diagnosis Code)** Axis I Diagnosis Date: ____/____/____
    AXIS I & II: AXIS I _____ (circle one: Primary, Secondary, Rule Out)
    AXIS I _____ (circle one: Primary, Secondary, Rule Out)
    AXIS II (If deferred, pls indicate)_____ (circle one: Primary, Secondary, Rule Out)
    AXIS II _____ (circle one: Primary, Secondary, Rule Out)
    a. AXIS III: ☐ None ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cardiac Problem ☐ Chronic Pain ☐ Cystic Fibrosis ☐ Eating Disorder ☐ HIV ☐ Hearing Impairment ☐ Hepatitis ☐ Lupus ☐ Mobility impairment ☐ Neurological disorder ☐ Obesity ☐ Pregnancy ☐ Post-partum ☐ Sickle Cell ☐ Traumatic Brain Injury ☐ Type I Diabetes ☐ Type II Diabetes ☐ Visual impairment ☐ Other Axis III _____
    b. AXIS IV: _____
    c. AXIS V *(Indicate GAF Score 1-100)* _____
11. **If member had previous behavioral hlth treatment w/i the past 6 mos. Select all that apply:** ☐ N/A ☐ Mntl Hlth ☐ Sub Abuse

12. Are there family members or significant others involved in the members treatment and recovery? ☐ YES ☐ NO ☐ N/A
    a. If yes, are any of the family members/significant others receiving their own MH or SA treatment? ☐ YES ☐ NO
13. Have you obtained consent to contact:
    a. School ☐ YES ☐ NO ☐ DENIED
    b. Medical Provider ☐ YES ☐ NO ☐ DENIED
    c. Previous behavioral health treatment provider ☐ YES ☐ NO ☐ DENIED ☐ N/A
    d. BH treatment provider for family member/significant other ☐ YES ☐ NO ☐ DENIED ☐ N/A
14. Who is the lead case management provider? ☐ None ☐ DCF Case Worker ☐ DCF Enhance CC ☐ CC (System of Care Collaborative) ☐ DMHAS Case Manager
15. Is the member currently taking psychiatric medications? ☐ YES ☐ NO
16. Is a psychiatric medication evaluation or medication management visit indicated? ☐ YES ☐ NO
17. Does member have co-occurring mental health and substance use conditions? ☐ YES ☐ NO ☐ Not Assessed
18. Is the member involved with the legal system? Please select all that apply
    a. ☐ Juvenile Justice ☐ Probation ☐ Parole ☐ Other Court ☐ N/A
19. Have you provided information regarding peer support or self-help options? ☐ YES ☐ NO
20. Effective date/Start date of authorization? (EX: 09/01/06): _____

FEDERAL REPORTING REQUIREMENTS *ONLY* FOR MEMBERS 0-17 YEARS OF AGE

21. SED (Seriously/Severely Emotionally Disturbed): ☐ YES ☐ NO ☐ UNKNOWN
22. Co-Occuring Disorder: ☐ YES ☐ NO ☐ UNKNOWN
23. Living Situation: ☐ Independent Living w/Supports ☐ Crisis Stabilization Residential ☐ Foster Care (Therapeutic or Professional) ☐ Foster Care (Standard) ☐ Group Home ☐ Homeless ☐ Jail/Correctional Facility ☐ Private Residence ☐ Psychiatric Residential Treatment Facility ☐ Residential Treatment Center ☐ Safe Home ☐ Shelter
24. Within the past 12 mos. has the child/youth been: Arrested? ☐ YES ☐ NO ☐ UNKNOWN
    a. Suspended/Expelled? ☐ YES ☐ NO ☐ UNKNOWN

ADDITIONAL REQUIRED QUESTIONS *ONLY* FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

1. Is the member currently maintained on Methadone? ☐ YES ☐ NO
    a. If yes, how long has the member received Methadone services?
    ☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs >
    b. If no, what has been the duration of the member's opioid use?
    ☐ Less than 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs or >
2. What other services are included in the treatment plan?
    a. ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ PCP/MD Follow-up
3. What is the ultimate treatment goal? ☐ Methadone Maintenance ☐ Abstinence

mbulatory Detox

From what substance is the member in need of detoxification? (select all that apply) ☐ Alcohol ☐ Opiates ☐ Benzodiazepines

Has the member had a previous detox in any setting in the past year? ☐ YES ☐ NO

If yes, number of detoxes in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4+

What is the identified discharge plan? (select all that apply) ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ Methadone Services ☐ PCP/MD Follow-up

Please note: If Axis I is Deferred (799.9 or V71.09) only one (1) unit/day will be authorized for Outpatient level of care. It will be necessary to submit a new Registration Form with the actual diagnosis to receive authorization for the additional units. Deferred Diagnosis NOT accepted for Family Support Teams (FST), Methadone Maintenance or Ambulatory Detox.